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Vesicular Monoamine Transporter (VMAT) 2 Inhibitors Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 1-800-454-3730.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for VMAT 2 inhibitors. Payment for nonpreferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered under the following conditions:

Tardive dyskinesia (Ingrezza or Austedo)

1. Patient meets the FDA approved age.
2. Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following:
    a. Involuntary athetoid or choreiform movements
    b. Documentation or claims history of current or prior chronic use (≥ 3 months or 1 month in patients ≥ 60 years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)
    c. Symptoms lasting longer than 4-8 weeks

3. Prescribed by or in consultation with a neurologist or psychiatrist.
4. Prescriber has evaluated the patient's current medications for consideration of a dose reduction, withdrawal or change of the dopamine receptor blocking agent causing the TD.
5. Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) score (attach AIMS)
6. For Ingrezza:
    a. Will not be used concurrently with MAO inhibitors (e.g., isocarboxazid, phenelzine, rasagiline, safinamide, selegiline, tranylcypromine, etc.) or strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, phenobarbital, rifampin and related agents, St. John's wort, etc.)
    b. Will not be used concurrently with other VMAT2 inhibitors
    c. Is prescribed within the FDA approved dosing
7. For Austedo:
    a. Patient is not suicidal or does not have untreated/inadequately treated depression
    b. Patient does not have hepatic impairment
    c. Will not be used concurrently with MAO inhibitors, reserpine, or other VMAT2 inhibitors
    d. Patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed 36 mg per day (18 mg twice daily)
    e. Is prescribed within the FDA approved dosing

If criteria for coverage are met, initial requests will be given for three months. Continuation of therapy will be considered when the following criteria are met:

1. Patient continues to meet the criteria for initial approval
2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS)

Chorea associated with Huntington' s disease (Austedo or tetrabenazine)

1. Patient meets the FDA approve age
2. Patient has a diagnosis of Huntington's disease with chorea symptoms
3. Prescribed by or in consultation with a neurologist or psychiatrist
4. Is prescribed within the FDA approved dosing
5. Patient is not suicidal, or does not have untreated or inadequately treated depression
6. Patient does not have hepatic impairment
7. Patient does not have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and
8. For tetrabenazine, patients requiring doses above 50 mg per day have been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor metabolizer or extensive metabolizer
9. In patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed the following:
    a. Austedo — 36 mg per day (18 mg single dose) or
    b. Tetrabenazine — 50 mg per day (25 mg single dose)

If criteria for coverage are met, initial requests will be given for three months. Continuation of therapy will be considered when the following criteria are met:

1. Patient continues to meet the criteria for initial approval
2. Documentation of improvement in chorea symptoms is provided

Preferred **Nonpreferred**

☐ Austedo ☐ Ingrezza ☐ Tetrabenazine ☐ Xenazine

Tardive dyskinesia (Ingrezza or Austedo): patient has **ALL** of the following:

☐ Involuntary athetoid or choreiform movement

☐ Documentation of a dopamine receptor blocking agent:

Drug name and dose: _____ Trial dates: _____

☐ Symptoms lasting longer than 4-8 weeks; date of onset: _____

Is prescriber a: ☐ neurologist ☐ psychiatrist ☐ other: _____

If other, note consultation date with a neurologist or psychiatrist: _____

Physician name, phone and specialty: _____

Has prescriber evaluated the patient's current medications for consideration of a dose reduction, withdrawal or change of the dopamine receptor blocking agent causing the TD? ☐ Yes ☐ No

Baseline AIMS score (attach results): _____ Date conducted: _____

For Ingrezza: Does patient have concurrent therapy with MAO inhibitors, strong CYP3A4 inducers or other VMAT2 inhibitors? ☐ Yes ☐ No

For Austedo:

Is patient suicidal or have untreated or inadequately treated depression? ☐ Yes ☐ No

Does patient have hepatic impairment? ☐ Yes ☐ No

Does patient have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors? ☐ Yes ☐ No

Is patient taking a strong CYP2D6 inhibitor? ☐ Yes ☐ No

Has patient been identified as a poor CYP2D6 metabolizer? ☐ Yes ☐ No

Renewal requests

Updated AIMS score from baseline (attach results): _____ Date conducted: _____

☐ Chorea associated with Huntington's disease (Austedo or Tetrabenazine):

Is prescriber a: ☐ neurologist ☐ psychiatrist ☐ other: _____

If other, note consultation date with a neurologist or psychiatrist: _____

Physician name, phone and specialty: _____

Is patient suicidal or have untreated or inadequately treated depression? ☐ Yes ☐ No

Does patient have hepatic impairment? ☐ Yes ☐ No

Does patient have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors? ☐ Yes ☐ No

Is patient taking a strong CYP2D6 inhibitor? ☐ Yes ☐ No

Has patient been identified as a poor CYP2D6 metabolizer? ☐ Yes ☐ No

For tetrabenazine doses above 50 mg per day, has patient been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor or extensive metabolizer? ☐ Yes ☐ No

Renewal requests
Document improvement in chorea symptoms: _____
_____
_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.